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Ethics Education to Empower Nurses to Effectively Consult the Hospital Ethics Committee

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May 2018

Acknowledgements

I wish to thank everyone who supported me through this DNP journey. I wish to dedicate this work in memory of my father Alban Bernard who never knew of my accomplishment but would have been incredibly proud.

I am extremely grateful to the Kaiser Permanente Nurse Scholars program for providing me the opportunity to complete this terminal degree. Additionally, I am blessed that my Chief Nurse Lori Armstrong and Patient Care Services colleagues supported me and provided oversight for my KP responsibilities while I was at class.

Thank you to Dr. Brian Budds my DNP chair for your support and guidance with my project. Your realistic advice and calm demeanor helped me focus and eased my stress. Also, I wish to thank Dr. Timothy Godfrey for his insight, expertise and passion for nursing ethics.

I was blessed to have met wonderful colleagues and friends in cohort 7. You have all touched my heart and enriched my mind. May we always reach out to each other for support.

Finally, I want to thank my family for your contributions. My son Billy LePage and mother Jane Bernard were my editors, while Andre Ware, Julie LePage, Katie LePage and Simone Ware assisted every time I had a technical question. Immense thanks to my husband Ramon for his love, patience and unwavering support during this entire two-year program.

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Abstract

Nurses interacting with patients and family members need support when the course of the patient's care becomes uncertain or conflicted leading to ethical concerns. Educating nurses about the purpose of the Hospital Ethics Committees (HEC) may support nurses with ethical concerns, alleviate moral distress and improve job satisfaction. Utilizing the HEC for ethically challenging care situations enhances the professional practice and supports the code of ethics for nurses. HECs which are often underutilized can provide valuable resources for nurses. This DNP project sought to increase the number of nurses' ethics consultations to the HEC after providing ethics education using a humanistic teaching framework. Education focused on nurses' experiences with ethical concerns and availability of the HEC. Findings revealed an increase in nurse requested consultations to the HEC. Nurse engagement with the HEC could be enhanced with increased nurse membership on HECs, opportunities for debriefings after ethically challenging cases and increased interactions with bioethicists.

Keywords: ethics consultations by nurses, hospital ethics committees and nurses, nurses moral distress, nursing knowledge of the nurse code of ethics and ethical climate in nursing

Ethics Education to Empower Nurses to Effectively Consult the Hospital Ethics Committee

Hospital ethics committees (HEC) address difficult decisions about patient care when health care providers are uncertain or conflicted about the appropriate course of a patient's plan of care. The course of care may raise ethical concerns for providers, especially when care is perceived to be contrary to a patient's wishes or futile given the course of the disease. Moral distress occurs when "one knows what is the right thing to do, but institutional constraints make it impossible to follow the right course of action" (Jameton, 1984, p. 6). Hospital nurses must have an outlet to address ethical concerns in the clinical setting. Often, once intensive care therapies have been exhausted, the nurse supports patients and families through the disappointing failures of advanced therapies. Patients and families may be disheartened or unaccepting of the patient care outcome. Nurses interacting with the patient and family at the bedside need support and should participate in ethical discussions with the physicians, patients and families. Educating nurses about the resources available from the HEC will support nurses' struggles with moral distress.

Problem Description

The Joint Commission on the Accreditation of Health Care Organizations (The Joint Commission, 1992) mandated that hospitals establish a process to consider and educate health care staff about ethical issues in patient care. Most hospitals address this mandate through the establishment of an HEC. Hospitals determine the structure and functions of HECs and as noted by McCabe (2010) HEC's vary in professional diversity, preparation of members and the formal functions they perform. Many HECs have novice members with limited ethics experience while other hospitals choose to hire bioethicists. Establishment of a robust HEC and a strategic engagement plan for nurses could benefit

the satisfaction and retention of nurses while addressing ethical concerns at the bedside.

Nurse engagement with the HEC at Kaiser Permanente Santa Clara (KPSC) is limited. As a large 327 bed tertiary care facility, many of the patient populations are critically ill and require specialty therapies only provided at this facility. Due to these complex care needs, the nursing staff are actively confronting challenging ethical situations. Review of the numbers of consultations to the HEC in 2016 revealed only nine ethics consultations, eight initiated by physicians and only one initiated by a nurse.

Each Kaiser Permanente facility has an HEC comprising physicians, nurses, social workers, clergy and community members. Kaiser Regional Ethics Committee led by Mathew Pauly, JD and Jana Craig, JD provide ethics expertise and consultation to the individual medical centers. At the Quarterly Regional Ethics committee meeting, the consultant data by facility is communicated. By comparison of other KP facilities, KPSC ranked fifth for total ethics consultations in 2016 but the lowest among the larger KP medical centers by patient census (Appendix A).

Nurse participation and education about the HEC has been limited at KPSC as evidenced by low nurse membership on the committee and insufficient nurse ethics educational programs. Recently in January 2017, this writer accepted the position as co-chair of the hospital HEC. It has been over nine years since a nurse held this position, which was previously occupied by a clinical social worker. Only one nurse from the Emergency Department was a member of the HEC. There was no nursing representation from inpatient nursing. Annual nurses' education about the HEC was comprised of a self-study written curriculum, with no opportunity for questions or engagement from the nurses. The content focused on the availability and purpose of the HEC and the contact

information for the committee. The professional obligations of nurses to the code of nursing ethics was not included in the educational material. The limited nursing education and engagement with the HEC contributed to scarce involvement of the inpatient nursing staff.

KPSC nurse satisfaction related to a speak up culture is measured annually using an employee satisfaction survey named People Pulse. A speak up culture ensures patient safety and quality care are maintained and healthcare staff are empowered to speak up to prevent harm or errors. Nurses are obligated to speak up as a patient advocate during ethically challenging situations (Rainer, 2015). The goal of this annual survey is to create a work environment that allows employees to utilize their talents and abilities to achieve organizational goals. The medical surgical nurses and nursing assistants are compared to the entire nursing organization which includes all nurses and nursing assistants employed at KPSC who participated in the survey. Two questions on the survey address staff comfort speaking up about ethical concerns. These questions demonstrated the following ratings in 2016:

1. I would feel comfortable raising an ethical concern or a compliance related issue to my immediate supervisor or someone else in management. Ratings demonstrated 85% medical surgical nurses compared to 78% overall nursing organization.
2. If management were informed of unethical behavior or a compliance related issue, I would have confidence they would respond appropriately. Ratings demonstrated 83% medical surgical nurses compared to 75% overall nursing organization (Appendix B).

Medical surgical nurses comprise those nurses and nursing assistants employed in the KPSC medical surgical nursing service line (approximately 280 staff). The overall nursing organization comprises every nurse and nursing assistant employed at KPSC (approximately 1500 staff). These nurse satisfaction scores have numerous contributing factors; however, they are of considerable interest for this project as an overall means to compare the integrity of raising ethical concerns between groups of nurses.

A recent HEC consultation exemplified the moral distress of KPSC bedside nurses. Moral distress as defined by Jameton (1984), occurs when constraints exist for the right course of action. These constraints can create feelings of anger, frustration, guilt, and powerlessness for the involved persons. In a case of a terminally ill patient, family members refused to consider comfort care measures but instead insisted on directing all nursing care. Critical comfort measures such as pain medications and positioning for comfort were denied to the patient per the family request. The nurses involved experienced moral distress centered on their inability to relieve the patient's suffering.

End of life decisions are often a frequent topic for ethics consultations and bedside nurses are at the front line of emotional support for patient and families. When end of life care decisions are contrary to a nurse's obligation to provide optimal care, nurses may experience moral distress. The HEC consultation in this case allowed the nursing staff to evaluate the ethical concerns impacting the case, and determine a beneficial multi-disciplinary care plan for the patient while supporting the Code of Ethics for Nurses.

Support for the bedside nurse experiencing moral distress was the motivating purpose for this DNP project. The project objective was to educate KPSC nurses about the HEC and measure nurse consultations to the HEC. As demonstrated in this recent end

of life consultation, the HEC consultation provided a positive discussion of the nursing plan of care and support for the nursing staff.

Available Knowledge

This scholarly review included Cochrane Database of Systematic Reviews, Medline, and CINAHL databases utilizing search terms: *ethics consultations by nurses (19)*, *hospital ethics committees and nurses (38)*, *nurses moral distress (684)*, *nursing knowledge of the nurse code of ethics (6)* and *ethical climate in nursing (101)*. The search screened for high quality, evidence-based findings. The search inclusion criteria were English language, publication dates between 2008-2017, and peer-reviewed journals. Exclusion criteria included articles without a direct focus on HEC utilization, such as specific case studies. Seven studies were selected after application of inclusion/exclusion criteria and relevance. Articles were appraised using the John Hopkins Non-Research Evidence Appraisal tool (Dearholt, & Dang, 2012). The resulting articles included qualitative research and case studies (Appendix C). Systematic review and expert opinion articles were included in the discussion, but not appraised. The scholarly review examined four themes related to the project. These included

- Establishment of ethics committees
- Nurse knowledge of ethics committees
- Code of ethics for nursing
- Hospital ethical climate and moral distress

Establishment of Ethics Committees

The 1976 landmark case of Karen Ann Quinlan, a young woman in an irreversible comatose state, first addressed withdrawal of life sustaining medical treatments and the concept of surrogacy for patients' incapable of deciding (McFadden, 1985). Karen Ann's

parents petitioned the New Jersey Supreme Court to have their daughter removed from mechanical ventilation. The premise was that Karen Ann had no reasonable possibility of recovery and her father was deemed her surrogate decision maker. The court opinion recommended to the medical community the use of HECs as a vehicle to address ethical issues (McCabe, 2015).

In 1992, Joint Commission on the Accreditation of Health Care Organizations mandated that hospitals establish a process to address ethical issues in patient care and educate health care providers. This Joint Commission mandate led to the establishment of HECs without clear definitions of structure or purpose. HEC's objectives have evolved to provide education, consultation, and policy oversight for bioethical concerns. Consultations to the HEC guide care decisions and provide support for care givers. As noted by McCabe (2015), the structure and functions of these committees vary considerably.

Nurse Knowledge of Ethics Committees

Appraisal of the literature revealed that nurses' knowledge and utilization of this valuable resource is limited. In a qualitative descriptive study, 75 nurses and physicians from four Canadian hospitals were interviewed about ethical conflicts and barriers and facilitators to consulting the HEC (Gaudine, Lamb, LeFort, & Thorne, 2011). The transcripts were analyzed using content analysis and findings indicated a lack of knowledge about HECs, lack of experience in managing ethical situations, and possible negative repercussions from other health care providers to be the primary barriers towards consulting an HEC. Suggestions for improved utilization of an HEC included HEC personnel available within the hospital departments, available information and education about ethics committees, organization interest in ethics and support for staff identifying ethical issues (Gaudine et al., 2011).

Jansky, Marx, Nauck, and Alt-Epping (2013) examined through questionnaires the experiences of 101 physicians (n=30) and nurses (n=71) employed in a large German medical center. The study examined utilization of ethics consultations and the expectations and objections towards formalized ethics consultations. Findings revealed that nurses and physicians both experienced a high frequency of ethical conflicts. Nurses expected more support from clinical ethics committees (58%) than physicians (40%) (Jansky et al., 2013). Nurses felt physicians acted based on their own ethical values and not those of the patient's values; therefore, physicians did not identify conflicting values. Both nurses and physicians most frequently discussed ethical issues with their peers. Overall, there was a nursing desire for increased accessibility to ethical consultations and follow-up discussions about ethical cases. The identified limitations of this study included a low response rate and a selective sampling bias.

Grady et al. (2008) investigated the relationship between ethics education and usefulness of ethics resources for nurses and social workers. Using a survey design, 1,215 participants from four U.S. states were sampled. Participants were surveyed about prior ethics education and resultant confidence in making ethics decisions, increased moral action and/or positive influences for utilizing ethics resources. Findings revealed most (57%) nurses and social workers had previous ethics education, with social workers often more educated than nurses (60% social worker to 51% nurses, $p = .003$). Participants with little to no ethics training were less likely to use an ethics consultation service (86%). Nurses and social workers in this study demonstrated overall confidence with preparation to address ethical decisions (73%), confidence in justifying ethical decisions (85%) and confidence in professional scope of ethical practice (80%).

Regarding moral action, social workers had a slightly higher degree of moral action than nurses ($F = 6.30$, $p = .012$). Findings suggest that ongoing ethics education in the workplace may

contribute to the use of ethics resources and instill more confidence in moral judgements (Grady et al., 2008). Limitations included mail in or internet based self-reporting survey without an observational component.

Goncalves de Brito and de Oliveira Santa Rosa (2017) conducted an integrative review of 35 articles examining nursing professionals' participation in clinical ethics committees from 1994 to 2016. Four theme categories were considered, namely the need for time to discuss ethical issues in committees, competencies needed to participate in ethics committees, ethics committees reducing moral suffering of professionals, and barriers and facilitators for the implementation in an ethics committee. The review identified the need for nursing staff to have access to ethics committees for discussions. Core competencies for participation on an ethics committee is desired. Lack of knowledge and lack of time were barriers to utilize ethics committees. Communication of committee activities and education were identified as potential improvements to utilize ethics committees (Goncalves de Brito & de Oliveira Santa Rosa 2017).

Code of Ethics for Nursing

The Code of Ethics for Nursing with Interpretative Statements 2015 delineates the ethical obligations of all registered nurses through nine provisions (see Appendix D). Specifically, provision six defines nursing's obligation to create a moral environment: "The nurse, through individual and collective efforts, establishes, maintains and improves the ethical environment of the work setting, contributing to a safe, quality health care" (Lachman et al., 2015, p 364). The code of ethics is a backdrop to examine the obligation of nurses to consider ethical dilemmas and collaborate with other health care providers when indicated through consultation to the HEC.

Numminen, van der Arend, and Leino-Kilpi (2009) reviewed empirical literature related to nurses practice and knowledge about the nursing code of ethics between 1980 to 2007. The

aim was to identify knowledge gaps and recommend improving knowledge and utilization of the nursing code of ethics. Fifty articles were sorted to five main domains of interest: education, nurses' knowledge, use of the code of ethics for nurses, content and function of the code of ethics for nurses. "Overall findings from this review identified that nurses' general knowledge and use of the codes is deficient" (Numminen et al., 2009, p. 390). Limitations of this review included varied study methodologies, small sample sizes, and varied settings and overall classification of the included studies. Suggestions for further research include analysis of the meanings and functions of the codes to nurses, relationship of the codes between nursing and other disciplines and research on the impact of the codes towards nursing educators and nurse executives.

Hospital Ethical Climate and Moral Distress

Moral distress may develop from ethical dilemmas and conflicts, and can be experienced as emotional pain. Jameton (1984) defined *moral distress* as "arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p.6).

A hospital ethical climate, often referred to as a healthy work environment, is a safe environment for a nurse to engage in moral decision-making (Parker, Lazenby, & Brown, 2013). In a descriptive correlational study of 61 registered nurses from two participating hospitals in Alabama, Parker et al. (2013) examined relationships between ethical environments and intensity and frequency of moral distress. Nurses were surveyed using the Moral Distress Scale and the Ethical Climate Survey scale. These two scales examined ethical environments and overall job satisfaction. The findings revealed a negative relationship between ethical climate and frequency of moral distress existed (as ethical climates increase, frequency of moral distress decreased) and

a negative relationship between ethical climate and intensity of moral distress (as ethical climates decreased, intensity of moral distress increased). An increase in overall job satisfaction related to an increased ethical climate. Limitations of this study included small sample size within two settings.

Rathert, May, & Chung (2015) surveyed 290 nurses at an acute care level one trauma center in the United States examining nurses' moral distress. The relationships of (a) frequency of ethical dilemmas, (b) moral efficacy, (c) communication about ethical dilemmas, (d) caring ethical environments, and (e) organizational ethics support to moral distress were examined. The significant findings revealed that the frequency of ethics issues influenced moral distress ($B = .28, p < .001$) and perceptions of organizational support influenced moral distress reactions ($B = -.37, p < .001$). Rathert et al. (2015) deduced that managerial support for formal ethics consultations, in addition to readily available ethics resources during times of ethical dilemmas, is necessary to positively impact moral distress. Limitations included sampling from one setting with cross-sectional data collection subject to common method bias.

Ethical environments reflect an organization's structure, rules and policies. Shafipour, Yaghobian, Shafipour, and Heidari (2016) examined 168 nurses' perceptions of the ethical environment in a large Iranian teaching hospital in a descriptive, cross sectional study. Findings revealed varied perceptions of the ethical environment in the different wards of the hospital. The Hospital Ethical Climate Survey (HECS) utilized in their study measures the ethical climate through staff perceptions of health care organizational practices towards challenging patient conditions with ethical implications (Olson, 1998). The HECS uses a five-point Likert rating scale, with scores of one or five referencing the lowest and highest agreement respectively. Findings revealed that the majority of HECS items were rated 3.5 out of 5. Managers received

the highest rating of responses by nurses while physicians were rated the lowest. The cooperative relationship between staff nurse and manager may explain these findings while the low mean scores between physicians and nurses represent opportunities for improved communication of shared care goals.

Ethical climate and moral distress were examined by Atabay, Cangarli, and Penbek (2015). An online questionnaire of 201 Turkish registered nurses was administered. The questionnaire measured responses using the Ethical Climate Scale and an adapted Moral Distress Intensity Scale. Findings demonstrated that moral distress had three dimensions: organizational constraints, misinformation and over-treated patients. Ethical climate had four dimensions: rules, well-being of stakeholders, individualism and organizational interests. Results demonstrated lack of time or resources (moral distress) and a positive relationship between rules (climate) and organizational constraints. No ethical climate type had a negative impact on moral distress intensity. Recommendations include addressing staffing shortages, developing a collaborative process for rules development, encouraging autonomy, improving nurse advocacy, improving physical environment and loosening budget constraints. Limitations included the single setting and lengthy questionnaire.

Grace, Robinson, Jurchak, Zollfrank, and Lee (2014) examined a clinical ethics residency program for nurses designed to decrease moral distress and strengthen nurse retention. The Nursing Competency in Ethics scale used as a needs assessment was completed by 820 staff nurses in two large New England medical centers. Overall, nurses recognized the importance of ethical decision making (94%). The aims of the residency program were to increase ethics capacity among registered nurses and enhance nurse retention by providing methods to address and resolve ethical issues. The educational program comprised an online study course, didactic

content and simulation experiences and individual mentoring. Preliminary program evaluations support the assumption that nurses confident in the health care goals and ethical responsibilities are less likely to experience moral distress and are more likely to remain in their positions.

Summary of Available Knowledge

Despite the mandates of the Joint Commission and the Nurses' Code of Ethics, HECs vary in effectiveness and those without a formal organizational plan become inactive and undervalued by the institution (McCabe, 2015). Instead of consulting an HEC, nurses and other healthcare professionals seek colleagues for guidance and advice about ethical concerns (Jansky et al., 2013). Goncalves de Brito et al. (2017) identified the need for nursing staff to have access to ethics committees for discussions. Strikingly, Numminen et al., (2009) identified that nurses' overall knowledge and use of the nursing code of ethics is deficient.

The benefits of nursing education about HECs have been identified by Rathert et al. (2015), Grady (2008), Gaudine (2011), Grace et al. (2014) and Goncalves de Brito et al. (2017). Perceptions of ethical environments may be positively influenced by unit manager's ethical support of staff nurses (Shafipour et al., 2016) and an improved ethical environment may alleviate moral distress and increase job satisfaction (Parker et al., 2013). Atabay et al. (2015) demonstrated a positive relationship between rules (climate) and organizational constraints and lack of time or resources (moral distress). Grace et al. (2014) developed a comprehensive ethics nurse residency program which may have contributed to fewer experiences of moral distress and improved nurse retention.

Conceptual/Theoretical Framework

The humanistic nursing theory by Paterson and Zderad (1988) is the guiding framework for this project. The principles of humanistic nursing theory include humanism and existentialism. Wolfe and Baily (2013) describe the humanistic nursing theory as identifying nursing as having a responsibility for the transactional relationship that demands a foundation in the nurse's existential awareness of self and others. It is each individual's responsibility to determine how the interaction will evolve or unfold. Humanism tries to understand the individual as part of his or her personal experiences while existentialism emphasizes self-determination and self-responsibility (Paterson & Zderad, (n.d.).

Nurses must understand themselves as human beings first and then view the unique humanism of the patient. Nursing represents a response to the human condition when a contextual relationship between the nurse and patient has developed (Paterson & Zderad, 1988). A basic function of this nurse patient relationship is the patient's call for help to the nurse. The patient's call for help is the essential component of nursing care and the nurse's response demonstrates nurse advocacy for the patient.

In 2007, Kleinman tested the humanistic theory as a framework for teaching nursing students. The humanistic teaching theory fosters human-centered nursing practices and requires nurses to reflect on individual values and professional responsibilities. This concept deviates from the knowledge and skill components of nurses training and instead examines humanism, existentialism and phenomenology.

According to Kleinman (2007) humanism reflects on the value of the individual and the responsibility that human beings have toward each other. Existentialism emphasizes the patient's self-determination which supports nursing's responsibility to advocate for patients.

Phenomenology illuminates the everyday experiences of nursing giving rise to increased understanding of values and meanings of the nurse- patient experience (Kleinman, 2007).

The essential intimacy of a nurse-patient relationship is crucial to a nurse's ability and willingness to consult the ethics committee. Nurses reflections on morally distressing care experiences support the tenets of Kleinman's theory. Promoting patient advocacy and the responsibilities that humans have towards each other align with nurses' engagement with the HEC. In the previously mentioned end of life consultation, the nurses were reflective of their personal anguish and professional responsibility to relieve suffering yet struggled with family barriers. Nurses engagement with the HEC provided support when patient family's desires for self-care decision making was at issue.

The educational content of this project provided examples of HEC clinical consultations projecting nurses' moral distress. During the education, nurses were encouraged to consider ethical situations in their own practice and learned that the HEC was available to support them. Review of the Nurse Code of Ethics examined the nursing role as a support for self-determination. This theory was selected for the project framework as a guide for nursing ethical obligations as part of professional nursing values.

Specific Project Aims

This project aimed to expand nursing ethics education and awareness of the HEC evidenced by an increase in nurse consults to the HEC by the end of Q1 2018. The PIO question was "In adult inpatient nurses at Kaiser Permanente Santa Clara (P), what is the effect of increased nursing education (I) on nursing consultations to the hospital ethics committee (O)?" Educating nurses about HECs may support nurses with ethical concerns, alleviate moral distress and improve job satisfaction. Careful examination of nurse engagement with the HEC was the

focus of this project. The work breakdown structure is depicted in Appendix E. Given the short duration of this project to transform the ethical environment, the ethics- related questions on the employee satisfaction survey and nurse turnover rates were monitored to determine long term impacts of the project. A list of operational definitions for this project are listed in Appendix F.

Methods

This DNP project applied a preliminary survey, titled Clinical Demographics Questionnaire (CDQ), used to evaluate nurses' knowledge about the HEC. This baseline data provided support and guidance for the educational intervention and monitoring of nurse generated HEC consultations. In this section, a comprehensive description of the intervention is provided. Outcome, process and balancing measures are delineated and the related ethical and budgetary considerations are described.

Ethical Considerations

Both the code of ethics for nurses and the Jesuit values associated with Jesuit education guided this project. The educational interventions were prepared and presented in an ethical manner with thoughtful respect for the sensitivity required when sharing personal ethically challenging experiences. Nurses who participated in the pre-educational questionnaire were volunteers and not coerced to participate. The educational interventions conducted in this project were included in the staff meetings in which participation is voluntary. Patient case examples that created moral distress were presented devoid of all identifying information of patient, staff or provider.

The professional obligation of nurses to adhere to the Code of Ethics for Nurses was highlighted in this educational project. As described in the Code of Ethics for Nurses, nurses are advocates for patients (provision 3) and supportive of an ethical

environment (provision 6). See Appendix D for Code of Ethics for Nurses. Nurses were reminded of the code's provisions, specifically the obligation to promote an ethical environment in the work setting and patient advocacy.

The Jesuit value of *Cura peronalis* – care of the whole person-guided this project. The vision of a University of San Francisco education is to inspire the whole person in which intellect is only a part of the individual's full development (About USF (n.d.). Nursing care focuses on the entire individual, not simply the physical illness. Reflection and intervention with ethically challenging situations engages a holistic approach to nursing care.

The Kaiser Foundation Research Institute Board approved this project and noted that a Kaiser Institutional Review Board review was unnecessary (Appendix G). However, the prospectus for this project requested a pre-education and post-education survey of the nurses which was denied based on Institutional Review Board limitations on nursing staff as a protected employee class. The project proceeded with a pre-educational survey (the CDQ) and educational interventions. The post educational survey was omitted. Instead, review of the employee satisfaction scores from 2015-2017 provided review of nurses' comfort level in raising ethical issues to management. There were no other identifiable ethical issues or conflicts of interest.

Contextual Elements

The nursing staff and nurse leaders are the primary stakeholders affected by this change. Nurses from the medical surgical, telemetry and critical care (CC) departments were invited to participate. Preliminary discussions about the project were conducted with the nursing leadership team and the Chief Nurse Executive (CNE). Her letter of support is included in Appendix H. The educational intervention required educational

time away from the bedside, engagement of the nurses, and expense approval from leadership.

The HEC committee members are also stakeholders in that more consultations will be requested of the committee, since a goal is to increase the number of consults to the committee. The HEC, including the co-chair, were provided with a presentation describing the project, expected outcomes and impact to the committee. With a low volume of consultations, the HEC discussed a plan to improve the consultation intake and assignment process with the expectation of increased consultations to the committee.

Patients, families and providers will be directly affected as an increase in ethics consultations are requested as part of the plan of care. Involvement of the HEC members may enhance communication about ethically challenging situations before a morally distressing situation develops. Involving the entire care team in ethics conversations, with inclusion of the patient and families when appropriate, will be impactful to the goals of patient care. For patients and families, ethics consultations can assist with challenging care decisions and lend support for care opportunities outside of the hospital.

Description of Intervention

Prior to the educational interventions for this project, the KPSC medical surgical, critical care and telemetry nursing staff were asked to complete a questionnaire about knowledge and interactions with the HEC. A total of 277 nurses completed the survey. During the nurses' annual training sessions, the writer invited registered nurses to complete the CDQ (Appendix I). This questionnaire was created by the writer based on a similar tool created by Neitzke (2007) and Jansky et al. (2013). Results from the CDQ are detailed in the measures section.

The planned education included a multi-phased approach to increasing nurses' awareness of the HEC through reflection on ethical concerns regarding everyday experiences of patient care. A video was created by the writer which emphasized nurses' obligations to the nurse code of ethics. Examples of morally distressing situations depicted in the video were intended to illuminate nursing experiences at the bedside as framed in the humanistic nursing theory. Post presentation, pamphlets, ink pens and phone number magnets were provided with the HEC consultation contact number (Appendix J). The intention of the pamphlets and magnets was to provide nurses a ready reference for the HEC and easy access to the HEC phone number. The HEC website was relocated to the front of the KPSC intranet site, and nurses were educated about the location during the video presentation. Access to the video was provided on the HEC website. Finally, enhancements to the nursing annual self-study written curriculum were updated for 2017-2018.

The participants in this project included the KPSC nursing education department. Nurse educators assisted with distribution of the CDQ and staff meeting education. Collaboration with the nurse managers in each of the involved departments was essential. The managers provided time during the staff meetings for education and supported nursing staffs' engagement with the HEC.

Educational sessions were provided to the staff from September to November 2017 during unit staff meetings. In total, 20 sessions with 7- 16 nurse participants were educated. Each educational session began with a review of the Code of Ethics for Nurses and a laminated handout for the nursing unit to post. The staff was asked to view the ethics video presentation and was offered time afterwards for questions and answers from the writer. The pamphlets and

pens were provided during the meeting to each participant. Revised new employee orientation provided staff knowledge about the HEC and expectations of the Code of Ethics for Nurses at KPSC.

Data related to numbers of consultations to the HEC are maintained by the HEC committee chairpersons and project manager. There was agreement among these members to note in the database whenever a nurse called in the consultation. The consultation database is maintained on a secure share-point site which is accessible only to the HEC co-chairs and the project manager.

To capture longitudinal data about the ethical environment at KPSC, the annual employee survey data was examined. This annual KP employee survey, the People Pulse Survey, evaluates the work environment annually. The goal at KPSC is to create a work environment that allows employees to utilize their talents and abilities to achieve organizational goals. People Pulse helps leadership determine which areas of the work environment succeed and identify areas for improvements. The People Pulse Survey includes a speaking up index which examines if employees feel valued and respected, have the ability to voice opinions and know that action is taken on their input. The integrity index specifically examines speaking up and actions related to ethical concerns.

Gap analysis.

The CDQ revealed that nurses know of the existence of the committee; however, they are not utilizing the services (Appendix K). In 2016, there was only one nurse-generated consultation to the HEC. The desired outcome was to increase the number of nurse consultations to the HEC by two or more by March 2018. Nurse education about the HEC was the proposed solution to closing this gap. As KPSC aims towards enhancing

professional practices, the goal to close this nurse education gap is in line with the mission and vision of nursing at KPSC. Nurse education was achieved with a comprehensive training program. Success was measured through increased nurse consultations to the HEC and potentially increased nurse satisfaction and retention.

Milestones.

The initial prospectus sought to examine pre-education and post-education components of nurses' understanding and engagement with the HEC. Due to prolonged discussions with the KPSC IRB, the final approval was not achieved until March 2017. While awaiting final approval, materials for training were created and the CDQ was devised. The HEC website was updated and relocated. The educational video was created with the assistance of two staff nurses and the hospital videographer. New nurse orientation was updated with plans to show the ethics video to new hires. Finally, the annual nursing educational module was revised for 2017-2018 publication.

Starting in June 2017, the CDQ was administered to adult services nurses attending the nurses' annual skills training sessions. The CDQ established a baseline understanding of nurses' knowledge of the HEC. At the end of November 2017, nurse education was completed and data collection of nurse-requested ethics consults was identified. In September, the 2017 employee satisfaction survey was administered to staff using an online survey format.

One looming conflicting event during the educational period was the end of the California Nurses Association contract on August 31, 2017. One nurse from KPSC was sent to KP regional offices for contract bargaining and weekly email messages were returned to the medical center from the bargaining team. During this period of time, the negotiations were cordial and productive. During this project there were no labor actions which was a concern at

the start of the program. See Appendix L for Gantt chart.

S.W.O.T Analysis.

The internal strengths for this project included the support of the CNE at KPSC and her focus on improved professional nursing practice. Having a nurse as the co-chair of the HEC was a strength. The CDQ identified additional strengths for the project, including nursing staff awareness of the HEC (81%) and nurses' understanding of their responsibility to engage the HEC (See Figure 1). Nurses also requested additional information about the HEC (67%). There was potential cost avoidance due to increased nurse work satisfaction and subsequent retention in their roles.

Figure 1. Knowledge of HEC and Nursing's Responsibility to Consult the Ethics Committee.

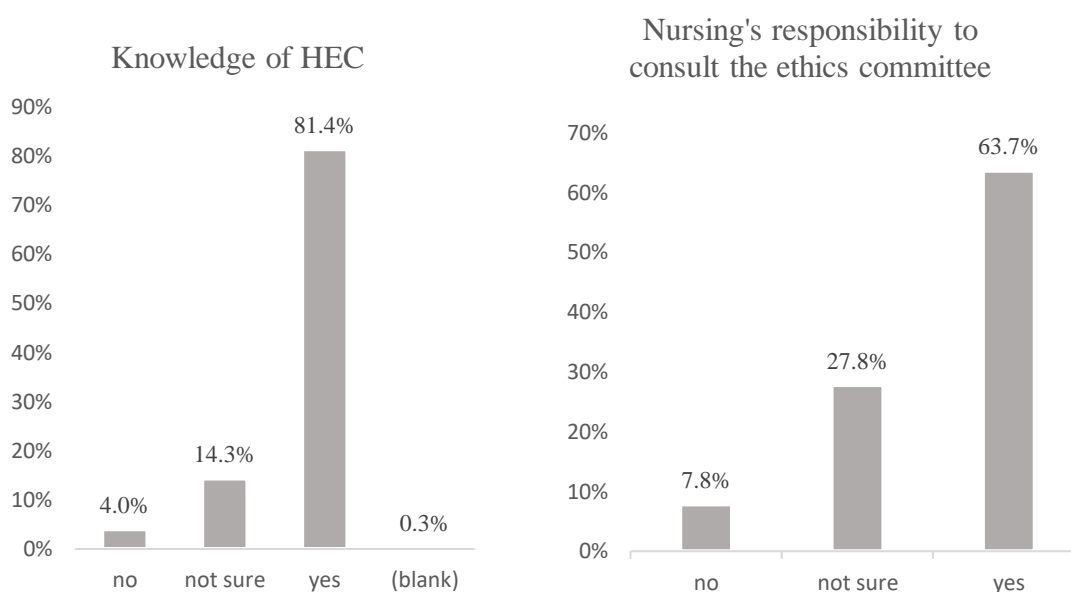


Figure 1. Responses to closed ended questions in the CDQ: #3 Do you know if there is an ethics committee at our facility? and #5 Is it nursing's responsibility to consult the ethics committee?

The internal weaknesses for this project included limited nurse requested consultations to the HEC and challenges for the HEC to take on more consultations. The CDQ data revealed that

despite awareness of the committee, only 49% knew how to consult the HEC. The nurses acknowledging previous contact with the HEC was low (8%). Nurses responded as not having or being unsure about ethical conflicts in the past twelve months was 84%, in contrast to 14% having experienced ethical conflicts in the same time period. Conflict frequency was only noted 19% by respondents (Figure 2). Finally, there was an overall lack of data exploring nursing beliefs about ethics and the ethical environment at KPSC.

Figure 2. Experience with Ethical Conflicts

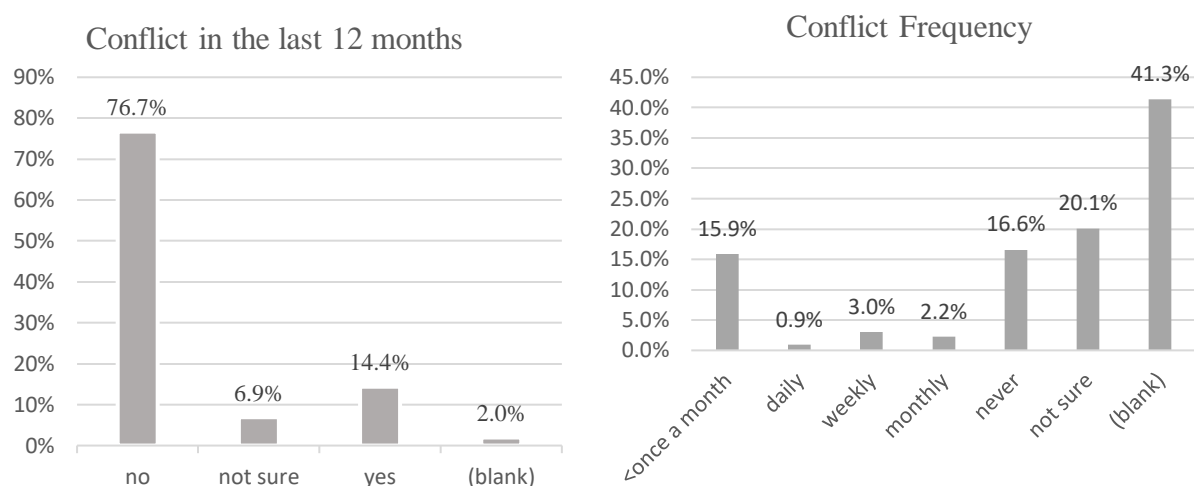


Figure 2. Responses to closed ended questions in the CDQ: responses to closed ended questions in the CDQ: #8 Have you experiences any ethical conflicts in the last twelve months? And #8a if so, how frequently do you experience ethical conflicts during nursing care?

External opportunities included the nursing leadership desire to develop exemplary professional practices which engage nurses and prevent attrition through enhanced ethical and professional practices. Resources and a potential model for KPSC exists in southern California KP in which a nurse ethicist is dedicated to each medical center. In northern California, the regional ethics committee provides resources to each medical center through phone calls and quarterly meetings.

External threats included the California Nurses Association ongoing union negotiations. Budget constraints generated from the uncertain healthcare market place were additional threats to the project. See Appendix M for a detailed Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis.

Responsibility matrix.

The first step for this project was to secure the hospital IRB approval for the study. Work has been divided into these categories; IRB approvals, study planning, education, data analysis and communication planning. A comprehensive responsibility matrix is demonstrated in Appendix N.

1. IRB approvals for KPSC were started but deemed unnecessary as the project was not considered research but a performance improvement project. The Doctorate of Nursing Practice statement of Non-Research Determination Study approval was secured from the University of San Francisco (Appendix O).
2. Project planning activities included establishing a project team, a survey tool, and educational materials. Finally, a timeline was developed for administration of the CDQ surveys, creating, and scheduling of the educational presentations. Staff meetings for delivery of the presentations were selected to not impact any labor action dates.
3. Education required the creation of the educational video. Nurses Sarah Johnson, RN and Cindy Corral, RN, volunteered to participate to prepare the educational video and creation of pamphlets.
4. Employee satisfaction survey data available for 2015, 2016 and 2017 were examined for trends.
5. Data analysis required data cleaning and review. Percentages were conducted comparing

items on the CDQ to determine baseline data. HEC consultation numbers by nurses were compared after the educational intervention. Consults to the HEC were retrieved from the HEC database. These data are presented as raw numbers.

6. Communication planning has been completed, including approvals by the HEC co-chair and the Chief Nursing Executive. Senior nursing leadership and the HEC members were periodically updated on the progress of the work.

Study of the Intervention

The impact of the educational interventions was assessed indirectly through consultations to the ethics committee and questions and answers from the nurses during each educational session. Assessing the impact of the education was challenging, since the reasons for the nurse-generated HEC consults may not be reflected during the consultation.

Measures

The measures chosen for this project include primary and secondary outcomes, and balancing measures. The primary outcome was the number of consultations to the HEC post educational interventions. A thorough examination of previously validated studies published in the literature examining the impact of nurses' education about HECs guided the potential impact and was examined in the knowledge section. The secondary outcome measures included employee satisfaction as measure on the integrity scores on the annual employee satisfaction survey. Nurse retention was also examined as a potential outcome and balancing measure of a supportive, ethical environment. Comparison to national benchmarks and validated published studies were examined to evaluate effectiveness.

Preliminary data collection.

The CDQ provided valuable information about the current state of nurses understanding of the HEC consultation process. Without post-survey data, the outcomes of the educational interventions were evaluated indirectly with acknowledgement of confounding influences.

Closed-ended questions were tabulated using Microsoft Excel and percentages were calculated. The data collection (n = 277) reveals that 81% of KPSC nurses know of the HEC (Figure 1). When asked if they knew how to contact the ethics committee, 50% responded affirmatively. Only 8% of nurses had previously contacted the HEC and 64% of nurses responded that it was nursing responsible to contact the HEC (Figure 1). When asked about ethical conflicts within the past 12 months, 14% expressed ethical conflicts occurred, 7% were unsure and 77% experienced no ethical conflicts in this time period. A sub-question about the frequency of ethical conflicts was left blank 41% and 17% acknowledged never having an ethical conflict (Figure 2). Overall, 67% requested more information about the HEC at KPSC.

The final statement on the CDQ: Please use the space below for any comments or questions about the hospital ethics committee generated 15 responses. These open-ended responses were analyzed and coded by content themes. Three main themes were identified:

1. Methods to consult the HEC
2. Desire for more discussion about ethical case examples
3. Frustration with futile care and response of ethics committee

The data collection process was monitored by clinical educators during the annual training classes. Participants were asked to voluntarily complete the CDQ at the start of the annual training class. The questionnaire forms were collected by the writer and maintained in a secure location. The data was collated by this writer into a Microsoft excel spread sheet. Questions without responses were coded as blank. If an answer to a question was ambiguous, the response was not counted and referred to as blank.

Attendance at the educational sessions were documented utilizing sign in sheets. Every nurse in attendance signed the sign in sheet verifying their attendance. There were 207 nurses trained within the medical surgical, telemetry and critical care departments. This represents 20% of the entire population of nurses in adult nursing care services (n = 1054).

Outcome Measures.

The primary outcome for this project was to increase nurse generated consultations to the HEC. Consultations are called to the HEC listen line which is a secure voice mail recorder. Messages from the listen line are retrieved Monday through Friday 9 am to 5 pm. HEC members complete the ethics consultation intake tool and plan next steps for the consultation. The standard procedure for documentation of consultations to the HEC includes a copy of the consult intake form populated into a confidential share point site. The intake form was also utilized as the documentation for the medical record. The ethics consultation intake tool requires identification of the consult requestor. The HEC consultation team has been instructed to identify the caller as a nurse or another provider. The consult data was reviewed monthly by the ethics co-chairs. The data on the consultation intake tool was validated for accuracy.

The employee satisfaction survey results which focus on questions related to the speak up ethics environment were the secondary outcomes for this project. The annual employee survey of medical surgical nurses provided a 2016 baseline evaluating staff opinions about raising ethical concerns. Each question demonstrated these ratings in 2016 but there was a noted increase in the medical surgical population in 2017 (Appendix B).

1. I would feel comfortable raising an ethical concern or a compliance related issue to my immediate supervisor or someone else in management (85% to 88%).
2. If management were informed of unethical behavior or a compliance related issue, I would have confidence they would respond appropriately (83% to 89%).

Employee satisfaction scores are generated by KPSC annually in late September. Participation is voluntary and highly encouraged. The survey responses are collected utilizing a Likert scale selection format and are tabulated electronically. Managers are provided anonymous access to the results for their department and are expected to focus efforts to improve identified areas of deficiency for the next year.

Balancing measure.

The balancing measure considered in this project was nurse turnover rates. Creating a supportive and ethical environment relates to nurse satisfaction and retention. Nurse attrition rates are monitored by the KP regional offices for all medical centers. From January 2016 – December 2016, the vacancy rate ranged from 1.5% to 0% with a termination rate ranging from 7.2% to 4.4% (Appendix P). Of note, multiple variables influence nurse retention including pay and benefits, work life balance, travel and leadership influences.

Budget

Nurses' job satisfaction improves in supportive ethical work environments which promotes nurse retention (Parker et al., 2013). Success was measured through increased nurse consultations to the HEC, increased nurse satisfaction and nurse retention following a nursing ethics education program. Voluntary nurse termination rates were examined as a potential opportunity for return on investment.

The expense of the initial educational efforts would be \$40,820, which included costs of HEC video creation, educational and HEC marketing materials and the writer's salary expenses. Future annual trainings, incorporated into existing new hire trainings and annual skills days would cost \$11,070 annually (Appendix Q). Retention of nurses which avoids the cost of onboarding would off-set much of this annual expense. The estimated cost to onboard two nurses is \$56,800.

The internal rate of return (IRR) for this proposed education plan assumes 173% IRR, assuming revenues of two nurses retained per year using an annual comprehensive training and 187% IRR utilizing an initial comprehensive training and passive annual review (Appendix R). Incorporation of either educational plan demonstrates positive returns. This approach was highly recommended for the professional benefits to nurses' ethics education, support of an ethical environment and the potential financial gains for KPSC.

Bell and Breslin (2008) noted that positive ethical environments are linked to increased job satisfaction and retention of healthcare professionals. Improving the ethical environment with improved nurse education and engagement to the HEC, may decrease nurses moral distress. Nurse voluntary termination rates would decrease in a healthy ethical environment. It is beneficial to continue developing the ethical environment at

KPSC with potentially beneficial impacts to nurse termination rates.

In the absence of exit interviews, it was difficult to predict how many nurses left KPSC due to the ethical environment which may be derived from insufficient ethics education. Annually the voluntary term rate for a KPSC nurse in 2016 through December 2017 ranged from 7.2% to 3.0%, with a noticeable downward trend in 2017 (Appendix P). The positive trend of voluntary term rates at KPSC cannot be directly linked to this project, since multiple factors influence nurse retention and satisfaction. As a balancing measure for this project, voluntary termination rates are a valid measure to consider longitudinally.

Cost Benefit Analysis

Three options were developed to consider future nursing ethics education and a proforma developed to examine the cost to benefit experience (Appendix R). This project sought to implement an educational program to enhance professional practice by supporting ethics at the bedside and encouraging nurses to consult the HEC for ethical concerns. The primary goal was to increase nurse consultations to the HEC through education. Secondary goals included increasing nurse satisfaction and improving nurse retention.

Option #1.

Continue with the current ethics educational program which verbally describes the HEC at new employee orientation and a self-study written curriculum annually. This option will not enhance nursing professional practice or engagement with the HEC. As the past HEC consultations by nurses has demonstrated, one consult per year is expected. There will be no additional budget implications or potential cost avoidance.

Option #2.

Implement the HEC education program directed at nursing staff during new employee orientation and annually. Increase the quality of education to include a video addressing nurses moral distress at the bedside and opportunity to enhance professional practices with a goal of increasing nurse consultations to the HEC. Proctor video viewing sessions with HEC members and educators available to answer questions and educate. Maintain ongoing in-services and messages to the nursing staff through online engagement, use of pamphlets, ethics website and ongoing in-services. Engage the nursing managers to encourage HEC consultations and support nurses' participation with the committee.

Option # 3.

This option would emphasize a one-time educational push, without the long-term maintenance. Create an HEC video for multiple venues without an HEC member or educator in attendance. The education will be provided and sustained in a passive manner.

Analysis

Both quantitative and qualitative data were collected for this project. The CDQ data was collected on paper survey tools and transcribed into Microsoft Excel. The data was aggregated and evaluated using percentages. Pivot tables were utilized to examine relationships between data points and displayed in graph formats. Likewise, numbers of participants were collected from paper sign in sheets. Total numbers of participants were examined as raw numbers in Microsoft excel. Numbers of nurse generated consultations were collected from the HEC share-point site and transcribed into Microsoft Excel. The timeline of educational classes and nurse generated consults were evaluated using a scatter plot diagram (Appendix S).

Qualitative data comprised questions and comments by the nurses during the educational sessions. These comments were recorded by the writer after each educational session. No notes or recordings were taken during the session. The comments were retrieved from this writer's memory. All post educational session recollections were classified by theme. Like themes were combined into groups and the overall messages were examined for patterns.

KPSC data available to the writer included the annual People Pulse surveys and nurse turnover rates. The data was reviewed as prepared by KPSC. Any impact on these measures because of the HEC educational intervention was impossible to predict due to the influences of many other factors. However, it was beneficial to review in a longitudinal manner any potential influence an improved ethical environment may have on nurse satisfaction and retention at the facility.

Results

The intervention of HEC education for the nurses incorporated the humanistic teaching theory. The presentation focused on professional expectations of the code of ethics for nurses and the self-reflection and values to care for another individual. The humanistic teaching framework proved a valuable platform for ethics education. Understanding the lived experience is at the heart of the theory. Nurses understanding of how their actions impact the patient and their call to duty enhanced the ethics educational experience. Examination of a nurse's own ethical conflicts allows a deeper connection to the educational experience.

The educational sessions were intimate with 7 – 16 nurses in each group. In total 207 nurses from all three shifts were trained in 20 sessions. At the end of each class, the nurses had opportunity to ask questions. The questions were sorted by themes including: methods of

contacting the HEC during the overnight shifts, requests for debriefings after HEC consultations and requests for help with morally distressing situations.

Evaluation of Outcome Measures

The aim of this project was to increase the numbers of nurse generated consultations to the HEC. From this standpoint, the project succeeded. From January 2017 until March 2018, there have been 17 total consults to the KPSC HEC and eight consults generated from nurses. The dates of the nurse generated consultations occurred in April 2017, August 2017, September 2017, December 2017, January 2018 and February 2018 (Appendix S). Compared to the dates of the educational intervention (September 2017 – December 2017), two generated consultations occurred before the intervention. The consultations prior to the education were requested by an oncology assistant nurse manager familiar with the writer's DNP project. This may have been a confounding influence which explains these early consultations.

The People Pulse scores related to ethical concerns demonstrated an increase in 2017 for the medical surgical organization (Appendix B). Of note, the overall nursing organization declined or demonstrated no improvement in these metrics. During this project, the nurses within the medical surgical organization were provided ethics education. By comparison, the nurses in maternal child health and perioperative services which represent the remainder of the organization were not provided the same education. There was no evidence that the ethics education intervention affected any change for these two ethics related questions. The impact on these two questions may have been influenced by management support of a speak up culture and support by physicians and other health care providers towards the nurses. Employee satisfaction scores will provide a measure to monitor as the ethics education is provided annually.

Evaluation of Balancing Measure

Nursing turnover may be indirectly related to moral distress in the work environment (Parker, et al 2013). Since December 2016 when KPSC nursing experienced a dramatic spike in annual termination rates 7.4%, the trend in 2017 has demonstrated a decline and stabilization (Appendix P). Of note, there was a decrease in voluntary termination rates starting in April 2017 which coincides with the start of this project. Retention of two nurses would save \$56,800 representing 173% rate of return supporting the fiscal benefit of this project. To improve understanding of nurse voluntary terminations, an exit interview tool would provide valuable insight of job dissatisfaction.

Discussion

The aim of this project to increase the number of nurse consultations to the HEC was achieved. The nurse consultations increased from one in 2016 to eight during the project period (January 2017- March 2018) which may have been affected by the ethics education intervention. The people pulse scores also demonstrated an improvement in response to ethical concerns within the medical surgical organization which was a targeted group for the education.

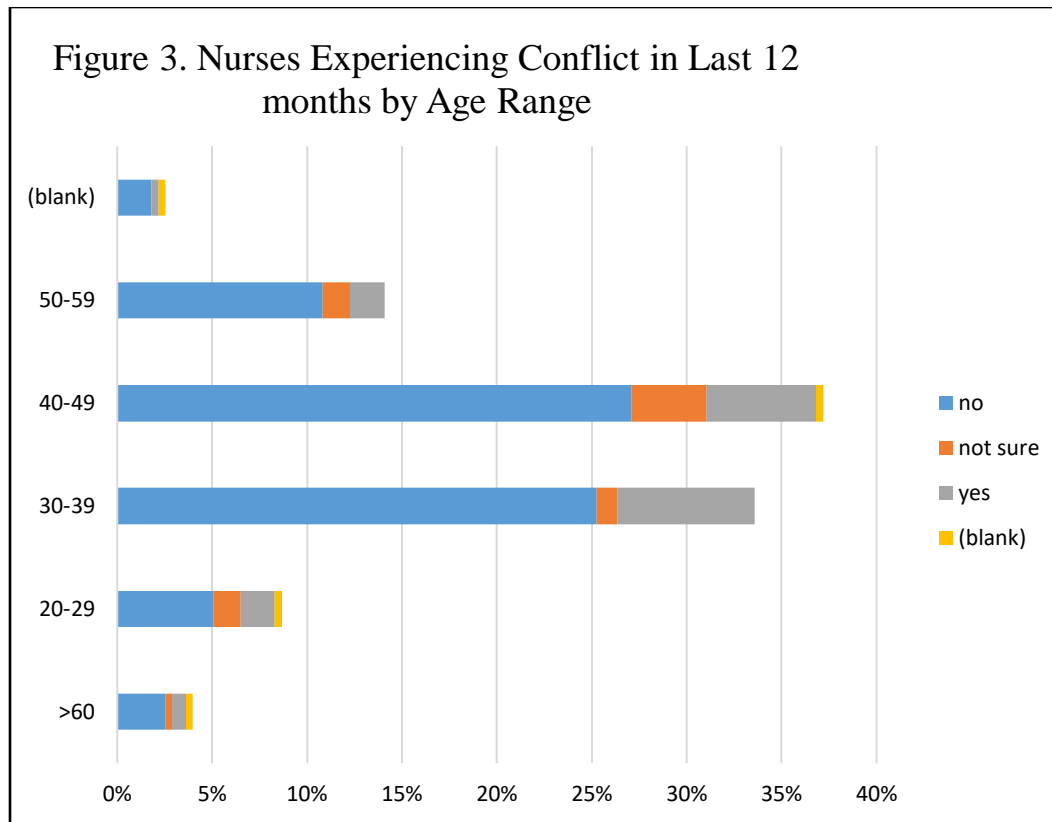
Nurses may consult the HEC irrespective of the educational interventions. In the future, continued nurse requests for HEC consultations may suggest a positive impact of the annual nurses education. Ongoing data collection for each HEC consult should include asking each nurse if the education provided affected their decision to consult the HEC.

In 2016 the HEC nominated a nurse as the committee co-lead. The participation of a nurse as a co-lead of the HEC may have affected nurses' willingness to consult the HEC. Rubinstein and Tabak (2012) conducted a similar questionnaire study with 87 nurses from five

Israeli hospitals. Their findings revealed that nurses would be valuable partners as members of the HEC and enlighten the HEC focus on professional nursing responsibilities.

A significant study by Fox, Myers, and Pearlman (2007) surveyed 600 United States general hospitals about the prevalence and functioning of HECs. The three particular findings relevant to this discussion were that an estimated 19% of U.S. hospitals have no HEC, the median number of HEC consults per year were three, and most consultations were conducted by clinicians, including nurses. Unfortunately, there has been no subsequent large-scale review of the prevalence and functioning of HECs in the literature. The overall low consultation rate was similar to the consultation rate experienced throughout KP. In this project, the response of the nurses requesting HEC consultations may have been positively influenced by the nomination of a nurse to the HEC. Nursing being prominently represented on the HEC may have broken down barriers for staff nurses and provided a welcome invitation to participate knowing that nurses' concerns would be evaluated from the nursing perspective.

The response on the CDQ revealed nurses aged 30 – 49 overwhelmingly denied ethical conflicts within the past 12 months compared to all other age groups. These age groups represent the two largest nurse groups by age (65%) at KPSC (Figure 3).



Nurses of this age group would identify with generation X which span the age range of 34 to 49. Generation X is commonly referred to as the neglected middle child. This generation experienced two income families, rising divorce rates, working mothers and economic challenges (Kane, 2017). In the workplace they embrace a hands-off philosophy towards management for independent, resourceful work ethics. Rainer (2015) identified generational differences with speaking up and advocacy for patients noting that generation X may be more comfortable with ambiguity based on the nature of the generation. This ambiguity may support generation X nurses' ability to remain silent or be less morally conflicted.

Interpretation

Nurse education and engagement with HECs supports the nursing competency for ethical decision- making. In a systematic review, Poikkeus, Numminen Suhonnen, and Leino-Kilpi (2013) found ethics support enhanced by ethics education, ethics rounds and HEC consultations.

The sustainability plan for this project will include annual education about the HEC and readily accessible references about the HEC in all departments within KPSC. Future nursing educational programs must encourage nurse participation in the HEC and increased nursing understanding about the HEC consultation process and objectives. Future HEC nurse consultation data collection should include a feedback loop which includes interviews with nurses to determine if the ethics education provided affected the decision to consult the HEC.

As HEC members, a competency program format and specialized education should be provided to all new HEC members. Cusveller and Schep-Akkerman (2015) developed a questionnaire designed to examine nurses' competence for participation in ethics committees. Dimensions of ethics and regulatory knowledge, communication, professional and ethical skills, commitment and self-awareness were all identified as important in a competency profile. Utilizing competency assessments for all HEC members will focus the ethics education. Well-educated and competent HEC committees will better support the needs of the patients, families and providers.

Nationwide, the HEC model is under-developed and needs refinement. Hospitals should have ready access to HEC and bioethicist resources. Providers are poorly equipped to address ethical issues at the bedside but are reluctant to consult an HEC. Recent literature examined mandatory ethics consultations to enforce the use to HEC services. Romano, Whalander, Lang, Li, and Prager (2009) found mandatory ethics consultations policies increased the overall number of ethics consults and may increase providers' ethics interactions, increase ethics education and provide nurses with potential ethics support.

Access to a bioethicist or nurse ethicist may not be fiscally prudent in all hospitals. The national average salary for a clinical ethicist is \$73,400 as of March 2018. An online video

bioethicist consultation service could supplement hospital ethics committees by providing an expert bioethicist. Using a video platform, the professional bioethicist can be contacted to provide expert opinion and assistance to the local ethics committee on how to proceed with challenging ethical consultations. The future of HECs must consider technology- based solutions to provide much needed ethics support to the bedside.

HECs should provide debriefings for health care staff at the conclusion of challenging ethical cases. Storch et al. (2009) recommend debriefings as a “moral space where everyone can speak freely and openly to address ethical concerns” (p. 24-25). The KPSC challenging end of life case prompted the co-chairs of the HEC to provide a debriefing session with the nurses. This strategy allowed the nurses to vent frustrations, ask ethical questions and validate their feelings of helplessness. The Code of Ethics for Nurses’ provisions protect the rights of this patient yet the optimal care and safety were not met which created stress for the nurses. Allowing the space and time to vent to ethics experts was valuable to the nursing team.

Nurses suffering from moral distress must have a safe venue to discuss ethically challenging concerns. A national response should be provided to better impact nurse retention, job satisfaction and combat nurse burnout related to ethical concerns at the bedside. Establishing an exit interview tool for utilization with nurses leaving the organization would be helpful to determine the impact of the ethical environment on nurse retention. Longitudinal assessments of the impact of highly engaged and competent HECs should be examined to evaluate nurse retention and ethical support at the bedside.

Limitations

The limitations of this project included the inability to conduct a post intervention survey. Follow-up data examining the impact ethics education provided with the humanistic teaching framework would direct the longitudinal plans for HEC education and nurse engagement. Additional questions on the CDQ focused on nurse participation as HEC committee membership would have further enlightened the conclusions of this project.

Conclusions

Nurse consultations to the HEC increased after an ethics education intervention. This finding follows other authors supporting an increased nurse education and engagement of HECs. As KPSC embarks to improve the professional nursing practices, there will be an increased focus on the Code of Ethics for Nurses. Utilization of the humanism theory encouraged reflection on the value of the individual and the responsibility that human beings have toward each other. An educational humanistic model focused on the Code of Ethics for Nurses and nurse consultations to the HEC which must be sustained at this facility.

Ethics education should be sustained to support the professional growth of the nursing staff, reduce moral distress, and support an ethical environment which supports nurse retention. Ethics education must be provided to the all nursing specialty areas and throughout Kaiser Permanente. Future projects should include utilization of a validated ethical climate survey to determine the baseline ethical environment. Understanding the baseline ethical environment will provide understanding of nurses', physicians' and leadership's impact on the nurses' perception of the ethical environment. Increasing the professional nursing practices at KPSC by conducting future nursing ethics projects at the facility provides an opportunity to achieve a healthy ethical environment and minimizes nurses' moral distress.

Funding

No grant funding was used to support this project.

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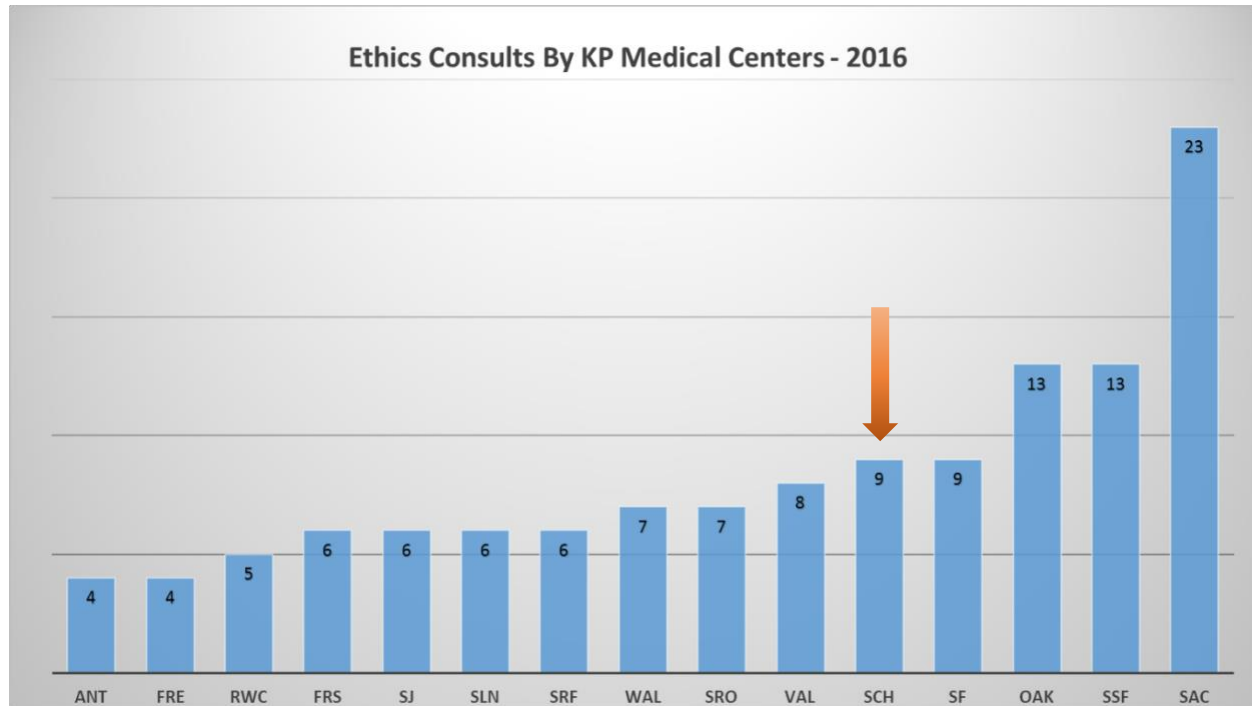
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Winland-Brown, J., Lachman, V.D., & Swanson, E.O. (2015) The new "code of ethics for nurses with interpretative statements (2015): Practical clinical application part I. *MedSurg Nursing*, 24(4), 268-271.

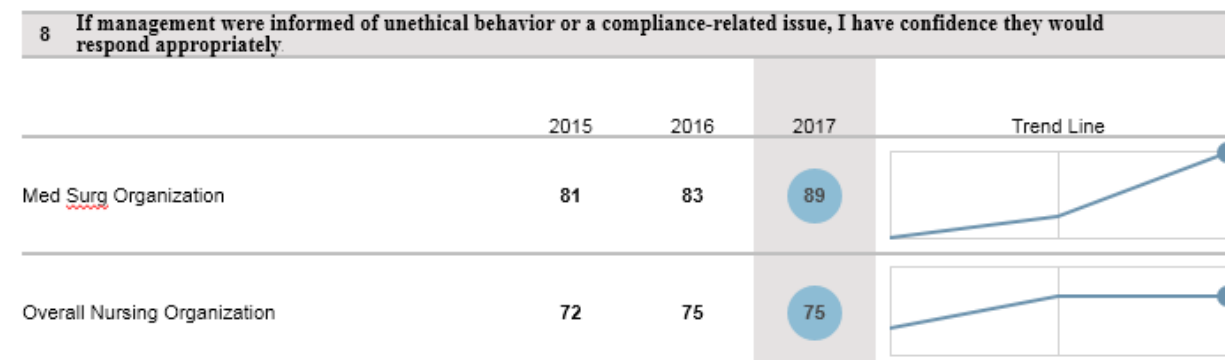
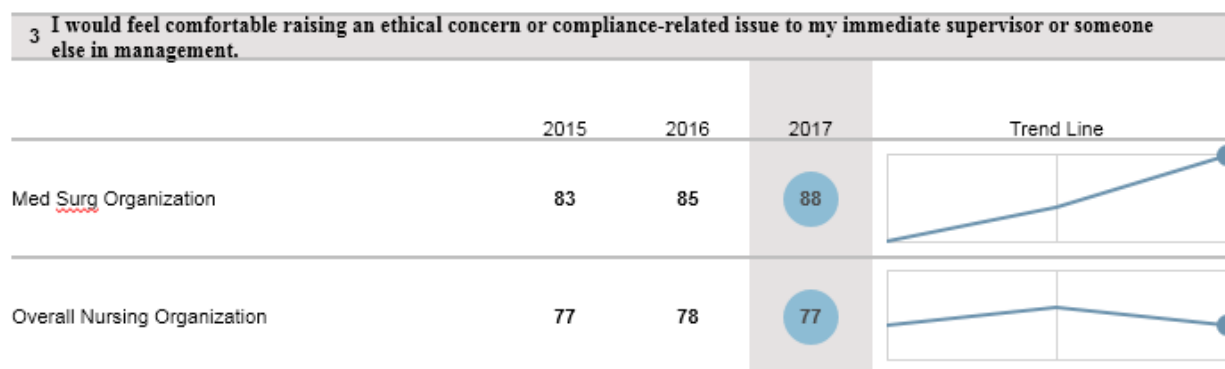
Wolf, Z.R., & Bailey, D.N. (2013). Paterson and Zderad's humanistic nursing theory: concepts and applications. *International Journal for Human Caring*, 17(4), 60-69.

Appendix A**Total 2016 Ethics Consults by Kaiser Permanente Medical Centers**

Appendix B

Kaiser Santa Clara People Pulse Results on Questions Related to Ethics

Trend Detail - Integrity Theme



Appendix C

Individual Evidence Summary Table

Dearholt, S.L., & Dang, D. (2012). Individual Evidence Summary Table. In Dearholt, S.L., & Dang, D. (Eds.), *Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines, Second Edition* (pp. 247-247). Indianapolis, IN: Sigma Theta Tau.

#	Author/ Year	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence level and Quality
1	Gaudine, A., Lamb, M., LeFort, S.M., & Throne, L. (2011)	Qualitative descriptive study	Convenience sample of 75 nurses, nurse managers and physicians from 4 Canadian hospitals	Barriers to use of HEC <ul style="list-style-type: none"> • Lack of knowledge about committee • Lack of experience consulting committee • Lack of experience ethics expertise on the committee • Fear of intervening with the patient and family • “Not my role” • Lack of informal and formal ethics supports Support for use of HEC include: <ul style="list-style-type: none"> • Ethics facilitator • Ethics education • Speedy consultation • Organizational interest in ethics • Knowing a member • Increasing expertise on the committee 	Process for HEC consultations varied between sites Geographical and cultural limitations of the sites	Evidence level III, quality good

#	Author/ Year	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence level and Quality
				Differences between professional groups existed		
2	Jansky, M., Marx, G., Nauck, F., & Alt-Epping, B. (2013)	Survey design	Voluntary participation of subjects included 101 nurses and physicians from one university hospital in Germany	Participants responses: <ul style="list-style-type: none"> Physicians more pessimistic about changing clinical conditions, focused on own ethical beliefs, not the patient's Competent ethics support expected (Nurses 58%, Physicians 40%) Structural integration of ethics into day to day work Ease of accessibility Reports about discussed cases needed Case related ethical reflections High frequency of ethical conflicts existed Communication about ethical conflicts occurred most frequently with colleagues in both groups 	Design and limited data, low subject response rate Volunteer participants may have experienced conflicts or had a particular interest in ethics Comprehensive details about the nature of conflicts in missing	Evidence level III, quality good
3	Grady, C., Danis, M., Soeken, K.L., O'Donnell,	Survey design	Random sample, mailed survey to 1215 nurses	Findings <ul style="list-style-type: none"> 57% of participants had ethics education in their professional programs 	Small response rate Self-reporting results not an	Evidence level III, quality good

#	Author/ Year	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence level and Quality
	P., Taylor, C., Farrar, A., & Ulrich, C.M. (2008).		and social workers in 4 US states	<ul style="list-style-type: none"> Ethics education influences confidence to make ethical decisions and moral action Ethics education positively influences use of ethics resources 	actual study of behaviors	
4	Parker, F.M, Lazenby, R.B., & Brown, J.L. (2013)	Descriptive correlational study (survey)	Voluntary participation by 61 nurses employed at two participating hospitals in Alabama	<p>1. A negative relationship between ethical climate and frequency of moral distress (as ethical climates increased, the frequency of moral distress decreased)</p> <p>2. A negative relationship between ethical climate and intensity of moral distress (as ethical climates decreased, intensity of moral distress increased).</p> <p>3. An increase in overall job satisfaction related to an increased ethical climate)</p>	Small sample size and experience within 2 limited settings (same state)	Evidence level V, quality good
5	Rathert, C., May, D.R., & Chung H.S. (2015)	Survey Design	Voluntary participation by 290 nurses employed at a trauma level 1 acute	Hypothesis findings revealed: 1. ethics issues did influence moral distress 2. moral efficacy did not decrease moral distress 3. communication about ethics issues was not related to moral distress 4. a caring ethical environment did not	Limitations include: a single setting, cross sectional data collection (common method bias), no review of	Evidence level III, quality good

#	Author/ Year	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence level and Quality
			care US hospital	relate to moral distress 5. organizational support was significantly related to moral distress 6. ethics voice would mediate relationships (most direct variable effects included frequency of conflicts and organizational support)	individual differences affecting moral distress, lengthy survey	
6	Shafipour, V., Yaghobiam, M., Shafipour, L., & Heidari, M.R. (2016)	Descriptive, cross sectional study	168 nurses' perceptions of the ethical environment in a large Iranian teaching hospital	<ul style="list-style-type: none"> Majority of Hospital Ethical Climate Survey (HECS) items were rated 3.5 out of 5 Managers received the highest rating of responses by nurses, representing cooperative relationships Physicians were rated the lowest; indicating opportunities for improved communication of care goals 	Not identified in the study	Evidence level III, quality good
7	Atabay,G., Cangarli, B.G., & Penbek, S. (2015)	Qualitative interview study	9 nurses from 3 different wards at a University Hospital in Norway	Themes included: <ul style="list-style-type: none"> Nursing work - painful business; constant time pressures, staffing shortage, lack of time to think and provide professional actions (education or mentoring new staff) Conflict about values, prioritization of nursing tasks, lack of leadership involvement in nurses' value conflicts, nurses 	Limitations include single setting, dual focus moral distress frequency and intensity led to a long questionnaire	Evidence level III, quality good

#	Author/ Year	Evidence Type	Sample, Sample Size & Setting	Study findings that help answer the EBP question	Limitations	Evidence level and Quality
				<p>valued a close relationship with the patient, felt unable to guide new nurses, poor staff cohesion</p> <ul style="list-style-type: none"> • Compromising principles of nursing care- missed care events “teeth brushing” was intentionally omitted due to time. Bad reputation of the nursing care • Emotional Immunization – nurses learn to ignore feelings despite violations of patient’s dignity. Learned un-involvement • Morally blinded and emotionally immune 		

Appendix D

Code of Ethics for Nurses 2015

Provision 1 – The nurse practices with compassion and respect for the inherent dignity, worth and unique attributes of every person.

Provision 2 – The nurses' primary commitment is to the patient, whether an individual, family, group, community or population.

Provision 3 – The nurse promotes, advocates for, and protects the rights, health and safety of the patient.

Provision 4 – The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care.

Provision 5 – The nurse owes the same duties to self as to others, including responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

Provision 6 – The nurse, through individual and collective effort, establishes, maintains and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Provision 7 – The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development and the generation of both nursing and health policy.

Provision 8 – The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

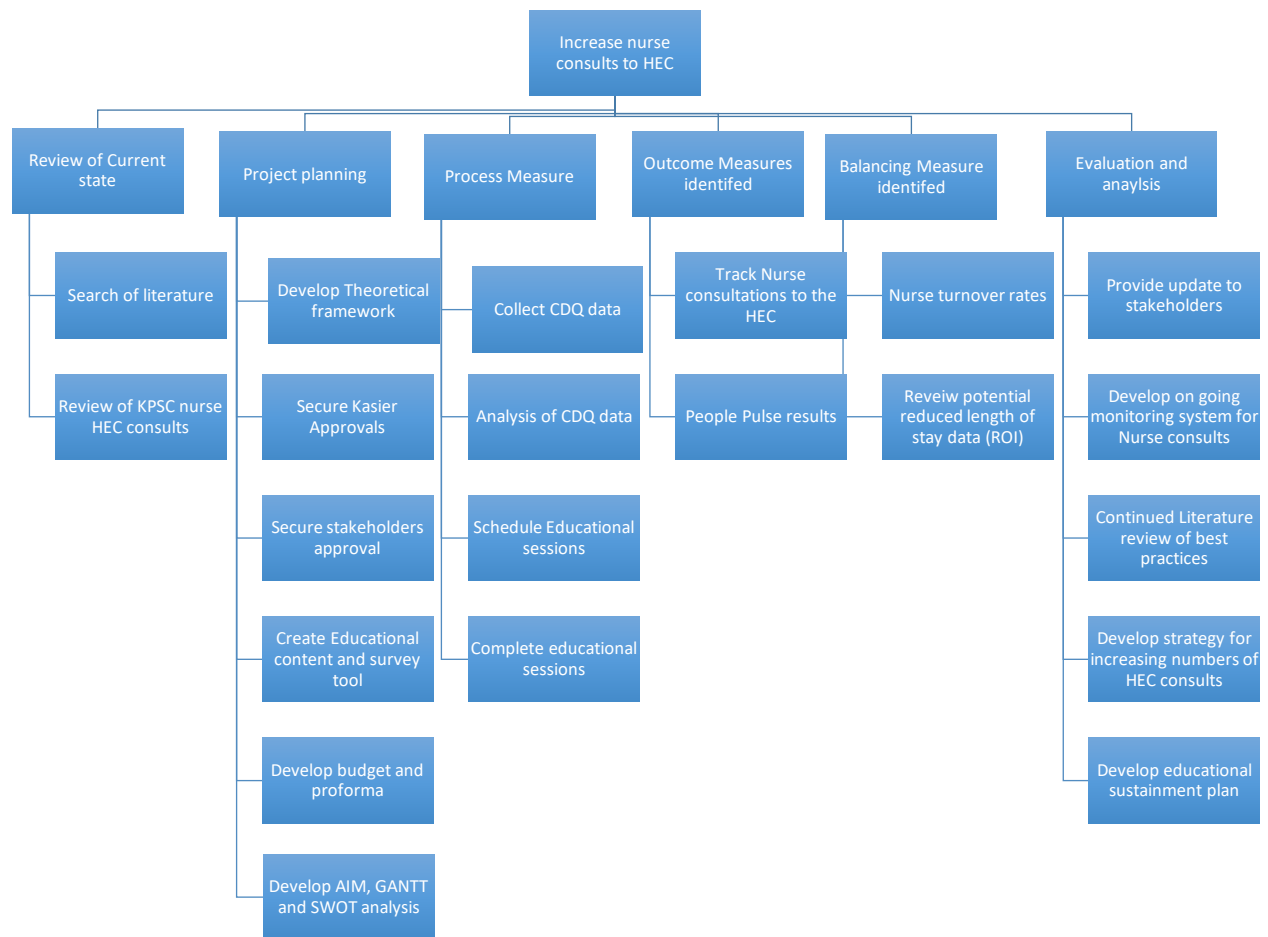
Provision 9 – The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain integrity of the profession and integrate principles of social justice into nursing and health policy

Lachman, V.D., O'Conner Swanson, E., & Winland-Brown, J. (2015). The new "code of ethics for nurses with interpretative statements (2015): Practical clinical application part II. *MedSurg Nursing* 24(5), 363-368.

Winland-Brown, J., Lachman, V.D & Swanson, E.O. (2015) The new "code of ethics for nurses with interpretative statements (2015): Practical clinical application part I. *MedSurg Nursing* 24(4), 268-271.

Appendix E

Work Breakdown Structure



Appendix F

Operational Definitions

1. CDQ - questionnaire created by the writer based on a similar tool created by Neitzke (2007) and Jansky et al (2013) intended to examine: nurse knowledge of the HEC, nurse consultations to the HEC, experience with ethical conflicts and requests for more information about the HEC utilizing closed ended questions. Opportunity for open dialogue was encouraged in one open ended question intended to elicit comments and questions. The CDQ also collected baseline demographic data about the participants.
2. People Pulse Survey – annual employee satisfaction survey for Kaiser Permanente in which results are used to monitor employee perceptions over time, evaluate strengths and opportunities and allows employees to take actions to succeed.
3. Speak Up Index – component of the People Pulse Survey which examines the speak up environment where employees feel valued and respected, have the ability to voice opinions and know that action is taken on their input. The integrity index component specifically examines speaking up and actions related to ethical concerns.
4. Speak up culture - ensures patient safety and quality care are maintained and healthcare staff are empowered to speak up to prevent harm or errors.
5. Nurse consultations to HEC – a phone call to the KPSC ethics consult line by a registered nurse requesting a consult on a patient under the nurse's care.
6. Nurse Turnover – percentage of nurses voluntarily leaving the facility, not including involuntary terminations or retirements.

7. Ethical environment – the existing practices, policies and conditions of the medical center environment which direct challenging ethical patient care concerns and the support provided for discussion and action.
8. Moral Distress – occurs when a person knows the right thing to do, but procedural constraints make it nearly impossible to pursue the right course of action (Jameton, 1984).

Appendix G

Facility Approval Letter



Subject/Title: RDO-KPNC-17-28; Ethics education to empower nurses to effectively consult the Hospital Ethics Committee

Date: June 12th, 2017

Dear Elaine LePage Ware;

Please see below determination outcome.

As the Research Determination Official (RDO) for the Kaiser Permanente Northern California region, I have reviewed the documents submitted for the above referenced project. The project does not meet the regulatory definition of research involving human subjects as noted here:

☒ **Not Research**

The activity does not meet the regulatory definition of **research** per 45 CFR 46.102(d):

A systemic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

☐ **Not Human Subject Research**

The activity does not meet the regulatory definition of **research involving human subjects** per 45 CFR 46.102(f): Human subjects means a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information.

Therefore, the project is not required to be reviewed by a KP Institutional Review Board (IRB). This determination is based on the information provided. If the scope or nature of the project changes in a manner that could impact this review, please resubmit for a new determination. Also, you are responsible for keeping a copy of this determination letter in your project files as it may be necessary to demonstrate that your project was properly reviewed.

Provide this approval letter to the Physician in Charge (PIC), your Area Manager, and Chief of Service, to determine whether additional approvals are needed.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric Garcia", is written over a horizontal line.

Eric Garcia
National Research Compliance Officer
Director, National Compliance in Research Support Program
Kaiser Foundation Research Institute
1800 Harrison Street
Suite 1600
Oakland, CA 94612
510-625-2397 (telephone)
510-625-2330 (fax)
Eric.F.Garcia@kp.org

Appendix H

Letter of Support from Agency



November 14, 2016

To Whom It May Concern:

I am writing to acknowledge support for Elaine LePage in completion of her evidence based quality improvement DNP project "Increasing Nurse Participation in the Ethics Committee" in partial fulfillment of her Doctor of Nursing Practice degree in the Executive Leadership program at the University of San Francisco. The Chief Nurse Executive and the Ethics Committee will have an opportunity to review any manuscripts that identify Kaiser Permanente, Santa Clara which are submitted for publication prior to submission.

This letter also verifies that Kaiser Permanente, Santa Clara has a memorandum of understanding with the School of Nursing and Health Professions at the University of Francisco for student clinical course work that is supervised by USF faculty.

Sincerely,

A handwritten signature in black ink that reads "Lori Armstrong".

Lori Armstrong, MSN, RN, NEA-BC
Chief Nurse Executive
Kaiser Permanente, Santa Clara

Appendix I
Clinical Demographics Questionnaire

Instructions: Answer each question. There are no right or wrong answers. Thank you for your participation

Department _____

Gender _____

1. What is your Age range?

☐ <20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ >60

2. How many years of nursing experience do you have?

☐ 0-5 ☐ 6-10 ☐ 11-15 ☐ 15-20 ☐ 21-25 ☐ >26

3. Do you know if there is an ethics committee at our facility? ☐ Yes ☐ No ☐ Not sure

4. Do you know how to contact the ethics committee? ☐ Yes ☐ No ☐ Not sure

5. Is it nursing's responsibility to consult the ethics committee? ☐ Yes ☐ No ☐ Not sure

6. I have previous experience with consulting clinical ethics committees ☐ Yes ☐ No ☐ Not sure

7. I have consulted the hospital ethics committee at some point in my career. ☐ Yes ☐ No ☐ Not sure

8. Have you experienced any ethical conflicts in the last 12 months? ☐ Yes ☐ No ☐ Not sure

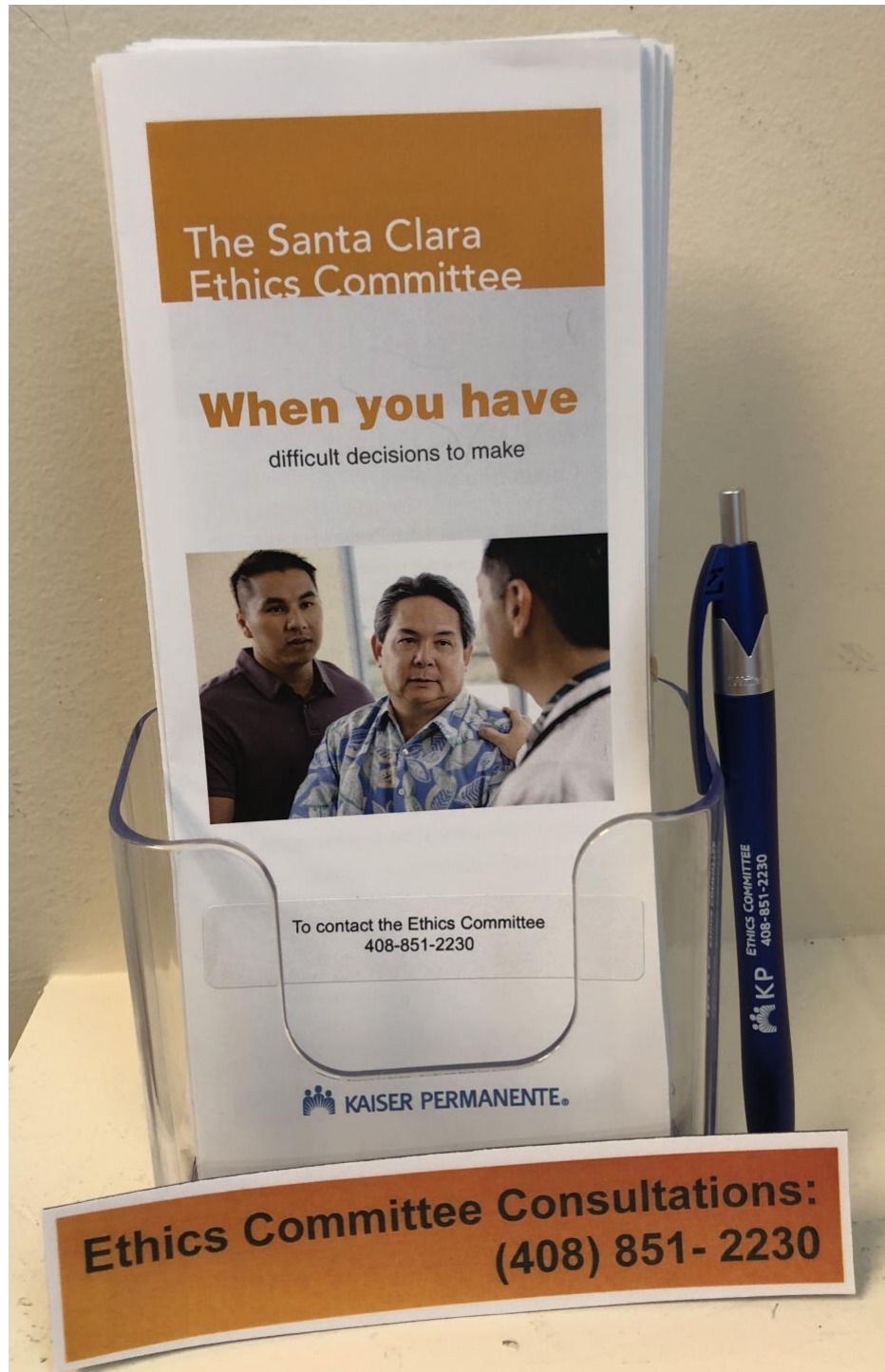
8a. If so, how frequently do you experience ethical conflicts during nursing care

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than once a Month ☐ Never ☐ Not sure

9. Would you like more information about the hospital ethics committee? ☐ Yes ☐ No

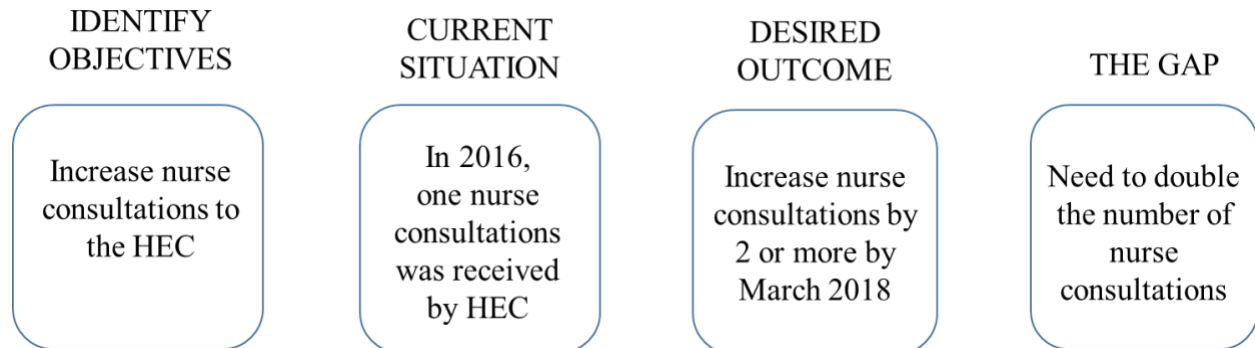
Appendix J

Educational Materials



Appendix K**Gap Analysis**

In adult inpatient nurses at Kaiser Permanente Santa Clara (P), what is the effect of increased nursing education (I) on nursing consultations to the hospital ethics committee (HEC)(O)?

**ACTIONS/REQUIREMENTS**

- ENHANCE THE NURSING EDUCATION
- INCREASE AWARENESS OF THE HEC FOR NURSES

Gantt Chart

[illegible]

Appendix M

S.W.O.T. Analysis

	Exploit	Mitigate
	<u>S</u> trengths	<u>W</u> eaknesses
Internal	<ul style="list-style-type: none"> • Willingness of CNE to support the educational plan • Professional objectives towards improved professional standards • Co-chair of the HEC is a nurse • Nursing staff are aware of the HEC (81%) • 67% of staff surveyed requested more information • Nurses understand their responsibility to engage the HEC • Potential cost avoidance re: nurse retention and increased satisfaction 	<ul style="list-style-type: none"> • Currently limited number of consultations to HEC which are managed by co-chairs on a part time basis • Challenges for existing HEC to take on additional consultations • Despite 81% awareness of HEC, only 49% recognized how to consult the committee • Nurses previous contact with HEC (8%) • Nurse failure to identify ethical conflicts (84%) • Nurses rating conflicts in last 12 months, only 14% had conflicts • Limited data on nursing beliefs about ethics and ethical environments
	<u>O</u> pportunities	<u>T</u> hreats
	<ul style="list-style-type: none"> • Develop exemplary professional practices which nurses engage nurses and prevent attrition • KPSC goals to promote professional nursing practices • Regional KP provides bioethicist support • KP in So. Cal has a bioethicist on site at each facility (potential model for No Cal) 	<ul style="list-style-type: none"> • C.N.A union activity, end of contract August 2017 • Uncertain healthcare market place leading to financial impacts to local budget

Appendix N
Responsibility Matrix

	Project Lead	Education	IT Support	Sponsor	HEC
Develop project plan	R			A	A
Project approval				A	A
Communicate with Stakeholders	R			I	
Develop educational materials		R	C		
Develop CDQ tool	R				
Develop and support budget	R			I	
Confirm timeline	R	C		I	
Collect data from multiple sources and analyze	R				R
Support increased HEC consults	C				R
Sustainability needs	I	C		I	R

Appendix O

DNP Statement of Non-Research Determination Form

Student Name: Elaine LePage Ware

Title of Project: Ethical Climate and Referrals to the Hospital Ethics Committee

Brief Description of Project: Ethics committees address difficult decisions about patient care when health care providers are uncertain or conflicted about the appropriate course of a patient's plan of care. The course of care may raise ethical concerns for providers, especially when care is perceived to be contrary to a patient's wishes or futile given the course of the disease. Nurses are not active participants on hospital based ethics committees and furthermore, fail to refer concerning clinical cases to ethics committees. Having an ethical environment allows nurses to be comfortable raising concerns and willing to engage in ethical discussions

A) Aim Statement: How does an educational program for (I) staff nurses (P) about the hospital ethics committee impact the hospital ethical climate (measured using the Hospital Ethical Climate Survey) (O) and nursing consultations to the hospital ethics committee (O)?

B) Description of Intervention: Nurses will be educated about the mission and vision of the Hospital Ethics Committee. The code of ethics for nurses will also be included in the education as the theoretical basis.

The Ethical Climate Survey will be administered pre- and post an education program (intervention). The intervention will be an educational program about the hospital ethics committee, its mission and vision. The value of an ethical environment which decreases nurses moral distress and advocates patient-centered care will be emphasized. Nursing's code of ethics will be the framework. Instruction will include video presentations by the members of the ethics committee describing their personal commitments to the ethics committee and why they are a member. Each committee member will also describe types of cases consulted by the committee and how the consultation was beneficial to the care plan of the patient. Post presentation pamphlets and phone number magnets will be provided with the ethics committee consultation contact number. The Ethics Committee Website will be updated with appropriate references and resources for further nursing education. Referrals to the ethics committee will also be identified pre- and post-intervention.

C) How will this intervention change practice? An educational program for nurses will increase awareness of consultations to the hospital ethics committee. Nurses will need education and easy to access references to enrich ethical environments within the nursing departments. Reinvigoration of the nursing code of ethics will impact the creation of an ethical climate which allows nursing staff to feel comfortable raising ethical concerns and engage in ethical discussions. Scores from the hospital ethical climate survey may provide the nurses a baseline understanding of the ethical environment of the hospital and lead other healthcare professionals

to campaign change.

D) Outcome measurements: The outcomes expected are increased consultation requests to the ethics committee and improvement on the Ethical Climate Survey.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:

(<http://answers.hhs.gov/ohrp/categories/1569>)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	x	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	x	
The project is NOT designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does NOT follow a protocol that overrides clinical decision-making.	x	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or untested methods or new untested standards.	x	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	x	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	x	
The project has NO funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	x	

The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., not a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	x	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: <i>“This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board.”</i>	x	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Elaine LePage

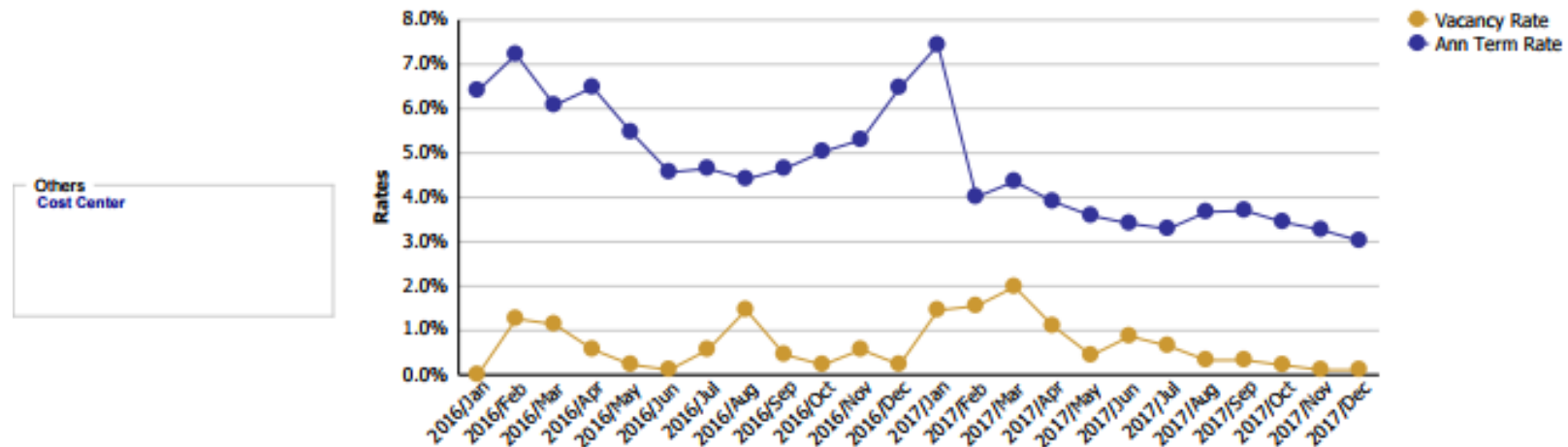
Signature of Student: _____  _____ **DATE**
1/4/2017

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Signature of Supervising Faculty Member (Chair): _____
_____ **DATE**

Appendix P

-Kaiser Santa Clara Nursing Vacancy and Termination Rates



	2016/Jan	2016/Feb	2016/Mar	2016/Apr	2016/May	2016/Jun	2016/Jul	2016/Aug	2016/Sep	2016/Oct	2016/Nov	2016/Dec	2017/Jan	2017/Feb	2017/Mar	2017/Apr	2017/May	2017/Jun	2017/Jul	2017/Aug	2017/Sep	2017/Oct	2017/Nov	2017/Dec
Requisitions Open	0	11	10	5	2	1	5	13	4	2	5	2	13	14	18	10	4	8	6	3	3	2	1	1
HeadCount	860	860	868	871	872	880	879	875	875	881	877	865	880	889	890	898	910	914	911	907	904	909	906	899
Vacancy Rate	0.0%	1.3%	1.1%	0.6%	0.2%	0.1%	0.6%	1.5%	0.5%	0.2%	0.6%	0.2%	1.5%	1.6%	2.0%	1.1%	0.4%	0.9%	0.7%	0.3%	0.3%	0.2%	0.1%	0.1%
Ann Term Rate	6.4%	7.2%	6.1%	6.5%	5.5%	4.6%	4.6%	4.4%	4.6%	5.0%	5.3%	6.5%	7.4%	4.0%	4.4%	3.9%	3.6%	3.4%	3.3%	3.7%	3.7%	3.4%	3.3%	3.0%

Appendix Q

Budget

EDUCATION COSTS FOR HEC	BASE YEAR	ANNUAL BUDGET
REVENUE		
COST AVOIDANCE/NURSE RETENTION *1	$\$67/\text{hr RN} = \8040 $\$80/\text{hr educator} = \6400 $\$74/\text{hr Preceptor} = \5920 $\$67/\text{hr RN backfill vacancy} \times 3 \text{ months} = \8040 28,400 total	Cost avoidance 2 RN per year \$56,800
TOTAL REVENUE	\$28,400	\$56,800
SALARIES AND WAGES		
DNP PROGRAM LEAD	$\$90/\text{hr} \times 80 \text{ hrs} = \7200	
VIDEOGRAPHER SERVICES	$\$75/\text{hr} \times 10 \text{ hrs} = \750	
2 NURSE ACTRESSES	$\$73/\text{hr} \times 5 \text{ hrs} = \$365 \times 2 = \$730$	
STAFF NURSE EDUCATION TIME *2 & *4	$\$70/\text{hr average nurse at OT} = \$105/\text{hr}$ total meeting costs = \$26,250	5,250 per month *5
DATA ENTRY SERVICES	$\$100/\text{hr} \times 5 \text{ hrs} = \500	
DATA ANALYSIS	$\$100/\text{hr} \times 8 \text{ hr} = \800	
NURSE EDUCATOR	$\$80/\text{hr} \times 10 \text{ hrs} = \800	
ADMINISTRATIVE ASSISTANT	$\$50/\text{hr} \times 40 \text{ hrs} = \2000	
ONLINE EDUCATION SPECIALIST *3	$\$60/\text{hr} \times 1 \text{ hr} = \60	\$10 monthly $\times 12 = \$120$ annually
HEC CONSULTATIONS*6		\$300/monthly = \$3600 annually
TOTAL SALARY AND WAGES	\$39,090	\$8, 970
SUPPLIES		
PAMPHLETS	\$1.50 ea, need 1000 = \$1,500	\$1,500 / yr

TABLE TOP BROCHURE HOLDERS	\$1.50 ea, need 20 = \$30	
ADVERTISEMENT: PENS AND MAGNETS	\$2.00 each x 50 = \$100	\$200/yr
OFFICE SUPPLIES	\$100	\$400/yr
TOTAL SUPPLY	\$1730	\$2,100
TOTAL REVENUE/COST AVOIDANCE	\$28,400	\$56,800
TOTAL EXPENSES	\$40,820	\$11,070
TOTAL COST AVOIDANCE – EXPENSES (PROFIT)	\$28,400 - \$40,820 = (\$12,420)	\$56,800 - \$11,070 = \$ 45,730

Assumptions:

***1** Assume 2 x RN onboarding of 120 hrs, educator cost 80 hr, RN preceptor time 80 hours and replacement position of 120 hrs

***2** Education during 1 hour staff meetings on OT (time and a half). Assume 25 staff meetings with 10 RN participants

***3** Online education specialist assume \$60/hr, required 1 hour per month = \$10 monthly

***4** Annual staff web-based learning for 20 min during annual skills days with replacement and OT factors for 5 months

***5** HEC consultations assume 1-hour duration of consult, 2 consultants at \$300/hr

Appendix R

Proforma

Option 1 – no change in current state, nurses passively trained using an annual read and sign online training. No expected cost avoidance for nurse turnover.

Option 2 – Comprehensive training which is sustained annually

Year	Base	Year 1	Year 2	Year 3	Year 4	
Revenue	\$28	\$57	\$57	\$57	\$57	
EBITDA (cash-based)	(\$14)	\$23	\$23	\$23	\$23	
%	-47.6%	40.0%	40.0%	40.0%	40.0%	
CapEx	\$-	\$-	\$-	\$-	\$-	
Maintenance CapEx		(\$0)	(\$0)	(\$0)	(\$0)	Terminal Value (5x)
FCF	(\$14)	\$22	\$22	\$22	\$22	\$114
NPV Incremental Cash Flow @ 15% WACC						\$93
NPV Incremental Cash Flow @ 30% WACC						\$50
IRR						173%

*Assumes revenues of 2 nurses retained per year. Comprehensive education in base year and multimodal education annually.

Option 3 – Initial comprehensive training, passive annual review

Year	Base	Year 1	Year 2	Year 3	Year 4	
Revenue	\$28	\$57	\$57	\$57	\$57	
EBITDA (cash-based)	(\$14)	\$25	\$25	\$25	\$25	
%	-47.6%	43.5%	43.5%	43.5%	43.5%	
CapEx	\$-	\$-	\$-	\$-	\$-	
Maintenance CapEx		(\$0)	(\$0)	(\$0)	(\$0)	Terminal Value (5x)
FCF	(\$14)	\$24	\$24	\$24	\$24	\$124
NPV Incremental Cash Flow @ 15% WACC						\$102
NPV Incremental Cash Flow @ 30% WACC						\$56
IRR						187%

*Assumes revenues of 2 nurses retained per year. Comprehensive education in base year and return to passively training using an annual read and sign online training.

Appendix S

Relationship of Ethics Classes to Nurse Generated Consults

Scatter Plot demonstration of number of nurses trained in ethics and nurse generated ethics consults by month.

